DATE

Surname, Forename
Date of birth

Health insurance

Questions and information regarding vaccinations with inactivated vaccines / dead vaccines
(including combined vaccines)

such as tetanus, diphtheria, hep A, hep B, meningococcal disease, polio, influenza etc.

Before administering the vaccination, the following information is requested:

1. Does the vaccine recipient have an acute disease?
   yes no
2. Does the vaccine recipient suffer from any other severe disease?
   yes no

if yes, which: .....

3. Is the vaccine recipient affected by a blood clotting disorder or does he/she take blood-thinning medications?
   yes no
4. Has the vaccine recipient had a nervous system disease or is he/she suffering from convulsions?
   yes no
5. Has the vaccine recipient any known allergies (for example, to chicken egg white or antibiotics)? yes
   no

if yes, which: .....

6. Did the vaccine recipient experience any allergic reactions, high fever or other unusual reactions after a previous vaccination?
   yes no

if yes, which: .....

7. For vaccinations in women of childbearing potential: Are you currently pregnant?
   yes ..... no

Additional questions and information about vaccinations with live vaccines
(including combined vaccines)

such as MMR, varicella, yellow fever, etc.

Before administering the vaccination, the following information is requested:

8. Does the vaccine recipient have an immunodeficiency disease (acquired, congenital, drug-induced)?
   yes no
9. Did the vaccine recipient receive immunoglobulin (gamma globulin) or a blood transfusion in the past 3 months?
   yes no
10. Was the vaccine recipient vaccinated in the past 4 weeks or is there a vaccination against other diseases planned in the next 4 weeks?
    yes no

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if yes, which ones and when: .....

11. Before yellow fever vaccination: Does the vaccine recipient have thymus disease or has his/her thymus gland been removed?
    yes no
12. For yellow fever vaccination only: Are you currently breastfeeding? (Yellow fever vaccine should be avoided in breastfeeding women.)
    yes no

Declaration of consent

Name of vaccine recipient.....

Date of birth.....

Date.....

Vaccination against (please tick / add as appropriate)

FSME	Version 2025-07	Influenza high-dose	Version 2025-07	Pneumococcal disease (polysaccharide)	Version 2024-10
Cholera	Version 2024-11	Influenza tetravalent	Version 2025-07	Td	Version 2024-12
Dengue	Version 2025-07	Jap. encephalitis	Version 2024-11	Poliomyelitis (IPV)	Version 2025-05
Td-IPV	Version 2023-10	MMR	Version 2024-12	Tdap-IPV (4-fold)	Version 2024-11
Hepatitis A	Version 2025-03	MMR-V	Version 2025-03	Tdap (3-fold)	Version 2024-10
Hepatitis B	Version 2025-01	Meningococcal ACWY disease	Version 2024-12	Rabies	Version 2024-11
Hepatitis A/B	Version 2025-01	Meningococcal B disease	Version 2024-10	Typhus	Version 2025-07
Hepatitis A/Typhus	Version 2023-05	Meningococcal C disease	Version 2024-10	Varicella	Version 2024-10
HPV	Version 2025-07	Pneumococcal disease (conj.)	Version 2025-03	Zoster live Vaccine dead Vaccine	Version 2021-08 Version 2025-07

Other vaccinations/ combined vaccines.....

The above vaccination(s) has/have been explained to me in detail during a consultation with my doctor and on the basis of a patient information sheet or information leaflet.

I have no further questions.

□ □ I give my consent to the recommended vaccination(s).

□ □ I refuse the vaccination(s). I have been informed about possible disadvantages of refusing.

Name of vaccine recipient.....

Place, Date.....

Signature of vaccine recipient or legal guardian Doctor´s signature

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